STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REHAB CTR OF SPRINGWOOD	5755 SHATTALON DRIVE WINSTON-SALEM, NC 27105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately document medication administration for 2 of 3 sampled residents (Residents #2 and #5) whose medications were reviewed. Findings included: 1. Resident #2 was re-admitted to the facility on 4/3/14 with multiple diagnoses including glaucoma, severe leg pain due to femur fracture and a history of strokes. The Minimum Data Set (MDS) assessment dated 2/20/14 found Resident #70 to be cognitively intact. Review of the resident's clinical record revealed	F 425	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	6/9/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/08/2014

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F 425	Continued From page 1 an admission order dated 4/3/14 for Xalatan 0.005% drops, 1 in each eye at bedtime (9 pm) and Azopt 1% drop in the right eye at bedtime (9pm) for glaucoma. Pravachol 20 milligram (mg) every evening at 9pm, due to a history of strokes as well as a new physician's order written on 4/5/14 for Norco, three times a day at 6am, 2pm and 10pm for pain management. The April 2014 Medication Administration Record (MAR) was reviewed. On 4/30/14 there were several missing entries at night, when Resident #70 should have received her Xalatan, Azopt, Pravachol and Norco. A pharmacy consultant review on 5/12/14 did not note the lack of documentation for missing medication administration on 4/30/14. The Director of Nursing (DON) was interviewed on 5/14/14 at 5:20 pm. She shared that she reviews the MARs for accuracy at the end of each month along with the Unit Manager and corporate nurse. She didn't recall that there were missing entries but stated that she would check with the other staff. The DON returned moments later and stated that the Unit Manager had detected medical errors when Nurse #1 was on duty 4/30/14, when he failed to initial the MAR and was counseled. The DON conveyed that she did not know if there was a full audit to ensure that no other residents were affected. On 5/14/14 at 7:00 pm Nurse #1 was interviewed. He stated that he was orientating a new employee on 4/30/14 and was responsible for following her on med pass to ensure that she pulled the right medications and initialed after administering them. He commented that new nurse hires have to work with an experienced nurse for three shifts before working independently and Nurse #2 was working her final orientation shift. He shared that he did not work a	F 425	F 425 Corrective Action: Resident #2 Xalatan, Azopt, Pravachol, and Narco medication have continued to be provided per MD order and documented by Nurse. Resident #5 Osteo-Bi-Flex, Prostat and Ultram have continued to be provided per MD order and documented by the nurse. Medication Error reports were completed for dose omissions for Resident #2 and #5. Unit Manger detected the missing documentation at the end of month review and Nurse #1 was counseled on 5/1/14 for failure to provide supervision with Medication Administration Record (MAR) documentation. Nurse #2 is no longer employed at facility. The results revealed twenty medication omissions. Each nurse responsible for the omissions received counseling. Identification of other residents who may be involved with this practice: All residents have the potential to be affected by this alleged practice. On 6/1/14, an audit of MARs was conducted to ensure all residents medication were initialed as given per MD order. Any medication that was not initialed was investigated and the Nurse contacted for correction and counseling. Beginning on 5/30/14, Nurses and Medication Aides were inserviced individually on performing a medication pass by Administrative Nurses, who observed the medication pass using the Medication Administration Observation	

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F 425	Continued From page 2 daily schedule, instead worked as needed and normally worked on another station. However, he stated that whenever he was on the cart, he always initialed the medication after he administered it but didn't know why he didn't catch that the new nurse was not initialing all of her medications. He stated that if he had realized it, he would have gone to speak to the resident who's cognitively intact and could tell him whether or not she had received her medication. The Unit Manager was interviewed on 5/14/14 at 7:20 pm. She shared that she reviewed the schedule from 4/30/14 and realized that Nurse #2 was oriented that night, quit after her assignment. At the time that she did her audit, she just pulled a sample of residents, so did not realize that another resident (Resident #5) was affected as well. The DON was interviewed on 5/14/14 at 7:30 pm. She stated that her expectation was for a nurse to sign the MAR as medications are passed. The nurse orientating was also responsible for making sure the nurse being trained initialed after passing meds and should always be working alongside the nurse. 2. Resident #5 was re-admitted to the facility on 2/5/14 with multiple diagnoses including osteoarthros and a pressure ulcer on sacrum. On the 4/28/14 quarterly MDS assessment, it was determined that he was cognitively intact. Review of the resident's clinical record revealed an April 2014 MAR where Osteo Bi-Flex Joint shield tablet was to be given at 5 pm for osteoarthros and there was no initial from the nurse that it was administered. In addition, Prostat AWC 30 cc (cubic centimeter) a supplement for wound healing, to be given at 5 pm and Ultram tablet 50 mg, used for pain, to be given at 5 pm, did not have a nurse's initial, to	F 425	Record. Observations included documentation of medications as administered and ensuring that all medications that are ordered are given as scheduled. Any nurse or med aide with a med error rate of 5% or greater was removed from duty and retraining offered; they were also notified if they could not achieve compliance with medication administration it would result in disciplinary action up to and including termination. Blanks in the MAR or circled initials without explanation would indicate that medications were not provided as ordered, and are also considered a medication error. Any staff members who did not receive in-service training were not allowed to work until training has been completed. As of 6/8/14 22 out of 28 of Nurses and Medication Aides have completed the inservice. Med Pass observations of Nurses and Med Aides indicate med error rates below 5%. Systemic Changes: Nurses and Med Aides will be observed on Med Administration randomly on all shifts by Pharmacy Consultant or designee each month. A score of 5% or greater will be reported to the DON for appropriate action including re-education, additional med observation opportunity, and may result in disciplinary action up to termination. Medication Pass Observation Tool was used to evaluate the medication pass and teaching was done during the med pass. Monday through Friday The Daily Clinical Meeting will review the results of any	

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F 425	Continued From page 3 document that it had been administered as ordered. The Director of Nursing (DON) was interviewed on 5/14/14 at 5:20 pm. She shared that she reviews the MARs for accuracy at the end of each month along with the Unit Manager and corporate nurse. She didn't recall that there were missing entries but stated that she would check with the other staff. The DON returned moments later and stated that the Unit Manager had detected medical errors when Nurse #1 was on duty 4/30/14, when he failed to initial the MAR and was counseled. The DON conveyed that she did not know if there was a full audit to ensure that no other residents were affected. On 5/14/14 at 7:00 pm Nurse #1 was interviewed. He stated that he was orientating a new employee on 4/30/14 and was responsible for following her on med pass to ensure that she pulled the right medications and initialed after administering them. He commented that new nurse hires have to work with an experienced nurse for three shifts before working independently and Nurse #2 was working her final orientation shift. He shared that he did not work a daily schedule, instead worked as needed and normally worked on another station. However, he stated that whenever he was on the cart, he always initialed the medication after he administered it but didn't know why he didn't catch that the new nurse was not initialing all of her medications. He stated that if he had realized it, he would have gone to speak to the resident who's cognitively intact and could tell him whether or not she had received her medication. The Unit Manager was interviewed on 5/14/14 at 7:20 pm. She shared that she reviewed the schedule from 4/30/14 and realized that Nurse #2 was oriented that night, quit after her assignment.	F 425	Medication Observation preformed. The Unit Manager will present any score 5% or greater error rate and action taken. Any issues will be reported to the Administrator and the Medical Director for appropriate action. The Clinical Meeting includes DON, Unit Manager, Support Nurse, Rehab Director, MDS, HIM, and other clinical staff as needed. Each month the pharmacy consultant will review each resident□s medication regime including observation of med administration, documentation and drug storage in the medication cart. The DON will be responsible to ensure all recommendations are reviewed and appropriate response recorded. Monitoring: To ensure compliance the Unit Manager or DON will conduct a review using the QA Survey Tool reviewing 5 nurses or medication aides ensuring that medications that are ordered are administered according to the medication schedule and that they are documented on the MAR. This will be done weekly for four weeks then monthly for three months. Identified issues will be reported immediately to DON or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the DON, Wound Nurse, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM, Dietary Manager and the Administrator.	

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